IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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CERTIFIED MAIL: 7005 1160 0000 1506 9681

June 16, 2008

Debbie Freeze, Administrator
Lewiston Rehabilitation & Care Center
3315 8th Street
Lewiston, ID 83501

Provider #: 135021

Dear Ms. Freeze:

On **June 5, 2008**, a Recertification and State Licensure survey was conducted at Lewiston Rehabilitation & Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 30, 2008**. Failure to submit an acceptable PoC by **June 30, 2008**, may result in the imposition of civil monetary penalties by

July 21, 2008.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 10, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 10, 2008**. A change in the seriousness of the deficiencies on **July 10, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 10, 2008** includes the following:

Denial of payment for new admissions effective **September 5, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 5, 2008**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 5, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **June 30, 2008**. If your request for informal dispute resolution is received after **June 30, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 135021	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/5/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON REHAB & CARE CENTER	**3315 8TH STREET LEWISTON, ID**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to ensure MDS coding was accurate for a type of restraint, DNR [Do Not Resuscitate] status, and for a toileting program. This affected 3 of 17 sampled residents (#s 1, 3, and 8). The findings include:

1. Resident #1 was admitted to the facility on 7/24/06 and was readmitted on 2/17/07 with diagnoses of congestive heart failure, chronic airway obstruction, vascular dementia, atrial fibrillation, paranoid state and hypertension.

Resident #1's most recent quarterly MDS assessment, dated 4/29/08, under "Devices and Restraints," documented, "Trunk restraint."

On 6/3/08 at 9:00 am, Resident #1 was in her room in a wheelchair facing the TV, with the bed immediately behind her. Her wheelchair was equipped with a lap buddy.

The RAI [resident assessment instrument] Version 2.0 Manual page 3-198 for physical restraint coding states concerning trunk restraints, "vest or waist restraint, belts used in wheelchairs," and that "Chair Prevents Rising," is defined as "Any type of chair with locked lap board."

On 6/4/04 at 1:50 pm, the MDS nurse and surveyor both reviewed the RAI Manual for physical restraint coding. The surveyor pointed out that "Chair Prevents Rising," was the correct coding for Resident #1's use of

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1

a lap buddy. The MDS nurse then stated, "It was my error in coding."

2. Resident #3 was admitted to the facility on 3/1/08 and was readmitted on 5/8/07 with the diagnoses of angina, history of coronary artery bypass graft, pacemaker, hypertension, atrial fibrillation, and coronary artery disease.

Resident #3's most recent annual MDS assessment, dated 4/30/08, documented the resident had no DNR advanced directive.

Review of the resident's record showed a completed Idaho Physician Orders for Scope of Treatment form, dated 9/13/07, with the box next to "Do Not Resuscitate" checked off.

On 6/4/08 at 2:20 pm, the DON was interviewed concerning the conflicting DNR status on the MDS assessment. She stated, "It was probably a mis-coding."

3. Resident #8 was admitted to the facility on 5/24/07 and readmitted on 11/27/07 with diagnoses of delirium due to opioid medication, dementia vascular type, behavioral disturbances, hypertension, congestive heart failure, diabetes mellitus type II and chronic renal failure with anemia.

The most recent significant change MDS, dated 3/28/08, documented the following:
* Daily decision making skills that were moderately impaired
* Frequent urinary incontinence.
* A scheduled toileting program

The RAI manual, Version 2.0 page 3-125 states, "Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day."

Review of the resident's Care Plan for incontinence, revealed an approach of: "routine toileting: toilet/offer urinal every 4 hours and as needed."

On 6/5/08 at approximately 10:30 am the MDS nurse was interviewed. She stated she was not aware of the criteria for coding a scheduled toileting program on the MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135021	A. BUILDING _____ B. WING _____	06/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON REHAB & CARE CENTER	3315 8TH STREET LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Arnold Rosling, RN, QMRP Amanda Bain, RN Lorraine Hutton, RN Lea Stoltz, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record FSM = Food Service Manager	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation and Care Center does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED JUL - 1 2008 FACILITY STANDARDS	
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to	F 246	**F246** **Resident Specific** The inter-disciplinary team (IDT) reviewed resident # 1's care regarding use of a personal hearing device & # 8's need to have her call light within reach. The plans of care were accurate. Staff is educated for consistent implementation and licensed nurse (LN) to monitor. **Other Residents** The IDT reviewed residents with hearing device needs and those with a need for call lights within reach. Plans of care are currently being implemented.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Debbie Fuge, E.D. | 6-24-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 ensure that the needs for a hearing device and a call light within reach were met for 2 of 14 (#'s 1, 8) sampled residents. Findings include: 1. Resident #8 was admitted to the facility on 5/24/07 and was readmitted on 11/27/07 with diagnoses of delirium due to opioid medication, dementia vascular type, behavioral disturbances, hypertension, congestive heart failure, diabetes mellitus type II and chronic renal failure with anemia. The most recent significant change MDS dated 3/28/08 documented the following: * Short and long term memory problems * Daily decision making skills that were moderately impaired * Identified of having behaviors, not of recient onset, disorganized speech, periods of restlessness, periods of lethargy and mental function that varied over the course of the day * Communication problems of hearing in special situations only, usually can make himself understood and sometime understands others * Had periodic episodes of resisting cares * Required setup and supervised oversight for eating * Required extensive assistance of one person for transfers, dressing, personal hygiene and bathing. Residents #8's care plan for communication dated 3/28/08, documented the goal, "will be able to successfully communicate daily as evidenced by needs being met." One of the approaches to achieve the goal was "personal hearing device: CNA to apply to resident's ears when resident is awake."	F 246	**Facility Systems** Staff are educated and supervised to implement each resident's individualized plan of care to include but not limited to, hearing devices and call light use. Re-education was provided related to hearing devices and call light use. LN's to monitor for ongoing implementation. **Monitor** The Director of Nurses (DNS) and/or designee will review residents weekly for proper implementation of the plan of care to include but not limited to, individualized interventions for hearing devices and call light placement. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The Performance Improvement (PI) committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 10,2008	

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F 246	Continued From page 2 On 6/2/2008 at approximately 3:30 pm, during the initial tour, the surveyor was introduced to the resident, who was lying on his bed. The resident had difficulty hearing the surveyor. The LN put on his "personal hearing device" and stated that the resident needed the device to hear with. The resident appeared to comprehend the introduction after the device was put on. On 6/3/08 between 12:05 pm and 12:45 pm, Resident #8 was continuously observed in the Lewis and Clark dining room. The resident did not have the personal hearing device on during the meal observation. * at 12:13 pm, the resident, when asked by a CNA in a normal tone of voice, what his choice off the menu was, did not indicate a choice, appeared disinterested and the CNA marked one of the items for him. * at 12:15 pm, a CNA asked in a very loud voice if Resident #8 wanted soup for lunch, the resident did not respond. The CNA gave him a bowl of soup, which he consumed. * at 12:32 pm, the meal of a barbecued sandwich arrived and the resident tried to eat it with some difficulty. * at 12:36 pm, an Activity Aide came by and offered assistance to cut the sandwich up. The resident responded with "what?" and "come again?" and appeared to have difficulty understanding. The staff had to speak in a very loud tone of voice before the resident allowed her to cut up the sandwich for the resident. 2. Resident #1 was admitted to the facility on 7/24/06 and was readmitted on 2/17/07 with diagnoses of congestive heart failure, chronic airway obstruction, vascular dementia, atrial	F 246		

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F 246	Continued From page 3 fibrillation, paranoid state and hypertension. Resident #1's most recent quarterly MDS assessment, dated 4/29/08, documented the following: * Short-term and long-term memory problems * Severely impaired cognitive skills for daily decision making * Extensive assistance of one person for transfers * Extensive assistance of one person for locomotion in room * Total dependence of one person physical assist for toilet use * Total dependence of one person physical assist for personal hygiene On 6/3/08 at 9:00 am, Resident #1 was in her room in a wheelchair facing the TV, with the bed immediately behind her. The call light was placed on the bed directly behind the wheelchair, out of reach of the resident. On 6/3/08 at 2:30 pm, Resident #1 was observed to be asleep in bed in her room. The call light had fallen down between the right side of the mattress and the wall and was out of reach. On 6/4/08 at 9:30 am, two CNAs assisted Resident #1 from her wheelchair to a standing position for pressure relief, placing the call light on the bed behind the wheelchair. After transferring the resident back to a sitting position and attaching her lap buddy to the wheelchair, the CNAs left the room. As each CNA was going down the hall away from the room in opposite directions, the surveyor caught up with one of the CNAs and informed her she had forgotten to place the call light within reach of the resident. The CNA then returned to Resident #1's room	F 246		

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F 246	Continued From page 4 and placed her call light within reach on her wheelchair. On 6/5/08 at 10:40 am, the Administrator and DON were made aware of the three different observations of Resident #1 having her call light out of reach. No further information was provided by the facility.	F 246		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to revise careplans to include interventions to prevent falls and urinary tract infections for 1 of	F 280	**F280** **Resident Specific** The IDT reviewed resident # 9's care plan for revisions related to fall prevention and urinary incontinence. The plan of care was updated as indicated. **Other Residents** The IDT reviewed other residents with falls and urinary incontinence for required revisions. Plans of care were updated as indicated. **Facility Systems** Residents are assessed upon admission, quarterly, and with change of condition. Plans of care are updated to meet current needs. Re-education was provided to LN's related to documenting care plan revisions for fall prevention and urinary incontinence. **Monitor** The DNS and/or designee will review residents weekly for appropriate plans of care to include but not limited to, fall prevention and urinary incontinence. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate.	

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F 280	Continued From page 5 10 (#9) sampled residents. The findings include: 1. Resident # 9 was admitted to the facility on 4/29/1998 with diagnoses of cerebral vascular accident with hemiplegia, seizure disorder, malaise, fatigue, and chronic urinary tract infections. The resident's last quarterly MDS, dated 3/21/08, documented the following: * Short and long-term memory impairment, * Modified independence related to cognitive skills for daily decision making, * Extensive one person physical assistance for bed mobility, transfers, dressing, and toilet use, dressing, and bathing, * Full loss of range of motion on one side [right side] for arm, hand, leg, foot, and * Frequent bladder incontinence. * History of falls within the preceding 31-180 days a. Review of nursing notes and physician's telephone orders for the months of June 2007 through June 2008, revealed that Resident #9 was treated for urinary tract infections in June, September, November, December, March, and May. A consulting urologist note, dated on 9/19/07, stated, " Introitus shows some lichenification of her labia and overall ... hygiene appears poor. The introitus is moderately stenotic and the urethral meatus is difficult to see. Perineal sensation appears to be intact." The urologist then then added, " [I] Also think if her perineal hygiene was improved this might reduce her infections." A follow-up urology consult note, dated 10/18/07, identified a long history of lower urinary tract	F 280	**Date of Compliance** July 10, 2008	

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F 280	Continued From page 6 infections,"Without apparent etiology," and stated, "[Resident #9's] incontinence and poor perineal hygiene have not helped in her infections." Nursing notes and IDT (Interdisciplinary Team) reviewed for September 2007 though November 2007 did not address the comments made by the urologist regarding the resident's perineal hygiene and incontinence in relationship to her ongoing urinary tract infections. The resident's care plan, updated 10/16/07, listed interventions for chronic urinary tract infections as: * Cranberry juice daily (5/1/07) * Labs as ordered and all urinalysis would be captured by fem caths (5/1/07) * Report signs and symptoms of infection (added 10/16/07) * Report urine odor, complaints of burning or blood in urine (added 10/16/07) This care plan also listed interventions for functional incontinence as: * Respond to call light promptly, keep call light within reach (5/12/98) * Document number of incontinent times per shift (5/12/98) * Provide incontinence protection (attends) at all times (4/29/07) * Administer medications as ordered (Oxybutynin) (4/12/07) * No caffeine or ETOH (alcohol) (5/18/2000) * Offer bed pan at 12 midnight and 4:00 am (added 10/16/07) Other than the instructions to report signs and symptoms of infection, report urine odor, complaints of burning or blood, and offer bedpan at midnight and 4:00 am (all added on 10/16/07), the resident's care plan was not modified to	F 280		

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F 280	Continued From page 7 thoroughly address the perineal hygiene and incontinence issues. Approaches to increase pericare were not added to the resident's care plan until 12/05/07, when the resident's primary physician ordered, "Pericare every shift in addition to incontinent care." Approaches for managing the resident's incontinence, listed in the resident's most recent care plan (4/20/08), continued to list the same approaches for functional incontinence as the previous care plan (2/19/08). The approaches instructed staff to offer the resident a bedpan at midnight and 4:00 am. However, an annual Bladder Status Evaluation, dated 1/11/08, stated the resident refused to get out of bed or use a bed pan at night, and "prefers incont [incontinent] care." An interview the resident's primary CNA, on 6/4/08 at 2:05 pm, confirmed the resident did not want to be woke at night to use the bedpan. The CNA stated that night staff managed the resident's incontinence by checking her every two hours and changing as necessary. Interviews with the DON and nurse consultant on 6/4/08 at 4:00 pm, and 6/5/08 at 8:30 am confirmed that Resident #9's care plan had not been updated to reflect her current incontinent care including the need to offer her the bedpan on the day and evening shifts, the frequency with which she should be offered the bedpan, nor that she was choosing incontinence versus the bedpan at night. b. Resident #9's care plan, dated 10/16/07, listed problems of, "impaired physical mobility" and "fall risk" related to seizure activity, weakness,	F 280		

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F 280	Continued From page 8 neuromuscular impairment, and osteoarthritis. A Resident Event Report Worksheet dated 12/28/07 stated, "IDT [interdisciplinary team] met 12/27/07 to discuss recent event fall [on] 12/26/07. Rsdt [with] hx [history] of seizures, weakness, R [right] flaccid side. Upon investigation rsdt was being toileted by aide. It appears that rsdt attempted to stand up quickly and aide was not prepared, [and] rsdt fell to floor. Plan: Inservice aide re: gait belt." Other than increased supervision and staff education, no other corrective actions were recommended on the report (including updating the care plan). Review of the care plan, dated 10/16/07 (effective for the time of the incident), as well as subsequent care plans, listed no additional modifications or updates regarding fall risk or fall precautions when toileting. Nurses notes, dated 4/23/08, documented the nurse was, "Informed that [Resident #9] was on the floor in the BR [bathroom]. [Resident #9] was found [with] R [right] leg curled under her. CNA stated rt [right] arm was under pt [patient] when she fell. ROM [range of motion] in RLE [right lower extremity] + [and] RUE [right upper extremity] is WNL [within normal limits] for elder. [Resident #9] Denies pain..." A Resident Event Report Worksheet dated 5/2/08 stated, "IDT [interdisciplinary team] met 4/24/08 to discuss recent event. Rsdt [with] hx [history] of R [right] sided weakness. Rsdt was being transferred from toilet to w/c [wheel chair] when it appears the w/c moved & [and] Rsdt went to floor. Plan: Inservice." The Post-Event Action portion of the event report documented the care plan would	F 280		

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F 280	Continued From page 9 be updated, supervision increased, and staff would be educated. Review of the care plan dated 4/30/08 listed no modifications or updates regarding fall risk or fall precautions when toileting. During observations of morning cares on 6/3/08 at 8:55 am, Resident #9 was observed to be transferred to from the bed to her wheel chair by two CNAs using a Hoyer lift. The CNAs stated the Hoyer lift was used during all transfers from the bed to the chair to prevent falls. During an observation of personal cares on 6/4/08 at 3:10 pm, two CNAs were observed to assist the resident to bed using a Hoyer lift and then place her on a bed pan. The resident voided in the bedpan, was given pericare, and then positioned for a nap. When asked if the resident used the bathroom during the day, the CNAs stated that, since a recent fall (5/08/08), the resident used the bedpan and attends versus transfering from the wheelchair to the toilet. Resident #9's care plan, dated 4/30/08, did not list the Hoyer lift or a bed pan (used during the day or evening) as interventions to prevent falls.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to meet professional standards for quality for: leaving medications at bedside, physician ordering the amount of a medication to be	F 281	**F281** **Resident Specific** The LN management team reviewed resident #'s 1, 6, & 18 related to medications at bedside, complete physician orders, and nebulizer treatment implementation. Physician clarification orders were obtained and the records updated as needed. **Other Residents** The LN management team reviewed residents appropriate for self-medication and current physician orders for	

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F 281	Continued From page 10 delivered and mixing medications against manufacturer's recomendations. These professional standards of quality affected 2 of 14 (#'s 1, 6) sampled residents and one (#18) random resident. Findings include: 1. Resident #6 was admitted to the facility 4/24/06 and readmitted on 3/11/07 with diagnoses of upper gastrointestinal bleed, chronic renal failure, hypertension and compression fracture. The most recent annual MDS dated 4/23/08 documented the following: * Short and long term memory were not a problem * Modified independence for daily decision making skills * Was able to make needs known and understood others * No mood or behavior problems * Independent with transfers and walking * Independent with setup help for personal hygiene and eating * Supervision with setup help for dressing * Continent of bowel and bladder On 6/2/08 at 6:43 pm, Resident #6 was observed in her room finishing her supper meal. There was a medication cup on the table with four pills. When asked, the resident indicated these were medications that she was to take in the evening. The LN who administered the medications was not in the room or in the adjacent hallway. On 6/3/08 at 10:10 am, Resident #6 was again observed in her room with a medication cup on the table with three pills in it.	F 281	completeness. Physician clarification orders were obtained as needed. Observations of LN were made to monitor for professional standards to included but not limited to, observation of medication ingestion and nebulizer treatment implementation. Re-education was provided as needed. **Facility Systems** Physician orders are reviewed monthly for completeness. Re-education was provided to include but not limited to, review of physician order for inclusion of the number of drops for eye solutions. Additionally, LN's have been retrained to follow the professional standard for observation of medication ingestion and nebulizer treatment implementation. Annual med pass LN skills checklists include the above professional standards. **Monitor** The DNS and/or designee will review two residents weekly to ensure physician orders are complete and observe one LN weekly on medication pass for monitoring resident medication ingestion and absence of mixing nebulizer solutions. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring, as it deems appropriate. **Date of Compliance** July 10, 2008	

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F 281	Continued From page 11 "Nursing Interventions & Clinical Skills, 3rd Edition" by Elkin, Perry, and Potter states regarding medication administration on p. 420, "Remain with the client until the medication is taken. Provide assistance as necessary. Do not leave medication at bedside without a prescriber's order to do so." Review of Resident #6's record and care plan revealed that the resident did not have a physicians order, was not assessed, nor was there a care plan for self administration of medications. Interview with the DNS on 6/4/2008 at 9:15 am, revealed the the resident was not on a medication self administration program and no further information was provided. 2. Random Resident #18 was admitted to the facility on 5/19/07 with diagnoses of hyponatremia, diabetes mellitus, hypertension and hypothyroidism. On 6/4/2008 at 7:10 am, the LN was being observed for a medication pass. The LN indicated that she could not administer the Systane Artificial Tears as the number of drops were not designated on the Medication Administration Record (MAR). The LN stated that she would need to contact the physician for clarification The June 08 recapitulated physician orders for Resident #18 stated, "Systane Artificial Tears QID (four times a day) both eyes dry eyes." The number of drops was not designated. 3. Resident #1 was admitted to the facility on	F 281		

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F 281	Continued From page 12 7/24/06 and readmitted 2/17/07 with diagnoses of congestive heart failure, chronic airway obstruction, vascular dementia, atrial fibrillation, paranoid state and hypertension. a. Resident #1's June 2008 recapitulation physician's orders were reviewed and an order dated 5/15/08 stated, "Artificial Tears to both eyes three times a day for dry eyes." The order did not specify the number of drops the nurse was to instill in Resident #1 eyes. b. Resident #1's June 2008 recapitulation physician's orders for nebulizer treatments were reviewed. They included Budesonide for SVN (single-dose vial nebulizer) 0.5/2ml per SVN two time a day and Duoneb (Albuterol Sulfate 3.0mg and Ipratropium Bromide 0.5mg per 3ml) UVN (unit-dose vial nebulizer) four times a day. During the medication pass on 6/4/08 at approximately 3:40 pm the LN was observed giving a nebulizer treatment to Resident #1. The resident was to receive two different nebulizer medications at the time. The medications were Duoneb and Budesonide (also known as Pulmcort). These two medications were mixed together in the reservoir bowl of the nebulizer. The mask was applied to Resident #1 face and the air compressor was turned on. The resident did receive a fine mist of air with the two medications being delivered together. Douneb is classified as a bronchodilator and Budesonide is classified as an anti-inflammatory corticosteroid. The manufacturer's recommendations for Pulmcort, dated 6/07 under the section "Information to Patients" second bullet states, "PULMCORT RESPULES should be	F 281		

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F 281	Continued From page 13 administered separately in the nebulizer." On 6/5/2008 at 8:15 am the pharmacist for the facility was interviewed and asked if the standard of practice was to administer the medications separately. She thought that was true but wanted to research and would get back to the surveyor. No further information was provided by the end of the business day following the exit conference on 6/5/08.	F 281		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to provide treatment and services to prevent urinary tract infections by not responding in a timely manner to a physician's concern to improve a resident's perineal hygiene, and by not ensuring a resident's care plan was updated to reflect current incontinent needs and approaches. This was true for 1 of 5 (#9) sampled resident's reviewed for urinary tract infections. The findings include: Resident # 9 was admitted to the facility on 4/29/1998 with diagnoses of cerebral vascular	F 315	**F315** **Resident Specific** The LN management team reviewed resident # 9 related to prevention of urinary tract infections and toileting plan, as well as for provision of education regarding the relationship of incontinence to urinary tract infections. The plan of care was updated and resident education was completed as noted in the statement of deficiency. **Other Residents** The LN management team reviewed residents with urinary tract infections for effective plans of care and resident education. The team notes that residents have effective treatment and plans of care to prevent urinary tract infections. **Facility Systems** Residents are assessed upon admission, quarterly, and with urinary tract infection for effective treatment and plans of care to prevent urinary tract infections. Plans of care are updated with any change of condition. **Monitor** The DNS and/or designee will review one resident with a urinary tract infection	

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F 315	Continued From page 14 accident with hemiplegia, seizure disorder, malaise, fatigue, and chronic urinary tract infections. The resident's last quarterly MDS, dated 3/21/08, documented the following: * Short and long-term memory impairment, * Modified independence related to cognitive skills for daily decision making, * Extensive one person physical assistance for bed mobility, transfers, dressing, and toilet use, dressing, and bathing, * Full loss of range of motion on one side [right side] for arm, hand, leg, foot, and * Frequent bladder incontinence. Review of nursing notes and physician's telephone orders for the months of June 2007 through June 2008, revealed that Resident #9 was treated for urinary tract infections in June, September, November, December, March, and May. A consulting urologist note, dated on 9/19/07, stated, "Introitus shows some lichenification of her labia and overall ... hygiene appears poor. The introitus is moderately stenotic and the urethral meatus is difficult to see. Perineal sensation appears to be intact." The urologist then then added, "[I] also think if her perineal hygiene was improved this might reduce her infections." A follow-up urology consult note, dated 10/18/07, identified a long history of lower urinary tract infections "Without apparent etiology" and stated, "[Resident #9's] incontinence and poor perineal hygiene have not helped in her infections." The urologist added, "The fact that she is already	F 315	weekly for effective plans of care and resident education. Any concerns will be discussed with the PI committee as indicated. The PI committee may adjust the frequency of monitoring, as it deems appropriate. **Date of Compliance** July 10, 2008	

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F 315	Continued From page 15 allergic to sulfa and Macrobid makes me not want to use quinolones for prophylaxis as certainly she will colonize with resistant organisms reducing one other choice of oral antibiotic available to us." The urologist indicated he would do a urethral meatal dilatation for noted meatal stenosis, would update a renal ultra sound, and discussed the consideration of a suprapubic cystostomy, but stated, "This is not a panacea and could also present with problems." Nursing notes and IDT (Interdisciplinary Team) reviewed for September 2007 though November 2007 did not address the comments made by the urologist regarding the resident's perineal hygiene and incontinence in relationship to her ongoing urinary tract infections. The resident's care plan, updated 10/16/07, listed interventions for chronic urinary tract infections as: * Cranberry juice daily (5/1/07) * Labs as ordered and all urinalysis would be captured by fem caths (5/1/07) * Report signs and symptoms of infection (added 10/16/07) * Report urine odor, complaints of burning or blood in urine (added 10/16/07) This care plan also listed interventions for functional incontinence as: * Respond to call light promptly, keep call light within reach (5/12/98) * Document number of incontinent times per shift (5/12/98) * Provide incontinence protection (attends) at all times (4/29/07) * Administer medications as ordered (Oxybutynin) (4/12/07) * No caffeine or ETOH (alcohol) (5/18/2000) * Offer bed pan at 12 midnight and 4:00 am	F 315		

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F 315	Continued From page 16 (added 10/16/07) Other than the instructions to report signs and symptoms of infection, report urine odor, complaints of burning or blood, and offer bedpan at midnight and 4:00 am (all added on 10/16/07), the resident's care plan was not modified to thoroughly address the perineal hygiene and incontinence issues. Approaches to increase pericare were not added to the resident's care plan until 12/05/07, when the resident's primary physician ordered, "Pericare every shift in addition to incontinent care." Approaches for managing the resident's incontinence, listed in the resident's most recent care plan (4/20/08), continued to list the same approaches for functional incontinence as the previous care plan (2/19/08). The approaches instructed staff to offer the resident a bedpan at midnight and 4:00 am. However, an annual Bladder Status Evaluation, dated 1/11/08, stated the resident refused to get out of bed or use a bed pan at night, and "prefers incont [incontinent] care." An interview the resident's primary CNA, on 6/4/08 at 2:05 pm, confirmed the resident did not want to be woke at night to use the bedpan. The CNA stated that night staff managed the resident's incontinence by checking her every two hours and changing as necessary. On 6/4/08 at 3:10 pm, CNA staff were observed to ask Resident #9 if she needed to go to the bathroom, assisted the resident to bed using a Hoyer lift, and placed her on a bedpan. The resident was given a call light and instructed to call staff when she was, "Done." The CNA staff	F 315		

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F 315	Continued From page 17 and the surveyor stepped out of the room and the resident put her call light on in approximately 10 minutes. CNA staff removed Resident #9 from the bed pan and gave her thorough pericare. The resident had voided a large amount of urine. When asked if the resident was generally continent, the CNA staff stated the resident was most often continent during the day time and on evenings. The CNAs stated the resident was usually able to answer, "Yes," or, "No," when asked if she needed to void, and was usually able to hold her urine until she was on the bedpan. They did state that she was occasionally incontinent if she waited too long to use the bed pan. The CNAs also stated, "since her fall" (5/8/08) the resident no longer used the bathroom to void, but offered the bedpan on day and evening shifts. Other than the annual bladder assessment (1/08), no documentation was found in Nursing notes, Interdisciplinary notes, or Resident Education notes reviewed for December 2007 through June 2008, that addressed the resident consistently choosing to not use the bedpan at night, nor that the resident was no longer using the toilet during the day and evening shifts and should be offered the bedpan. In addition, no evidence was found indicating the increased risk of infection, caused by incontinence, had been discussed with the resident or her family. Interviews with the DON and nurse consultant on 6/4/08 at 4:00 pm, and 6/5/08 at 8:30 am confirmed that Resident #9's care plan had not been updated to reflect her current incontinent care including the need to offer her the bedpan on the day and evening shifts, the frequency with which she should be offered the bedpan, nor that	F 315		

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F 315	Continued From page 18 she was choosing incontinence versus the bedpan at night. In addition, it was confirmed that there was no documentation addressing educating the resident (and family) regarding the risk of urinary tract infections with her choice to choose incontinence, and not use the bedpan, at night. On 6/5/08 at 10:00 am the DON displayed a copy of a Resident/Family Education Record, and a Careplan Update, dated 6/5/08, which addressed use of a bedpan at night to, "Assist in the prevention of urinary tract infections."	F 315	Phone conversation with the DON on 7/3/08. Resident #9's Plan of care was up-dated after falls; up-date was completed prior to the end of the annual survey. KD	
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 2. During the survey the following chemicals were observed unsecured: a. On 6/3/08 at 9:00 am, the shower room on the 300 hallway was observed to be unlocked and the door ajar. Inside the shower room was an open cabinet. The chemicals inside the cabinet were accessible. Inside the cabinet were multiple bottles of shampoo, shaving cream and hair conditioner. In addition to the personal hygiene items, bottles of Oasis disinfectant were present marked "Warning, Do not Drink Keep out of reach. Hazardous to humans and domestic animals, corrosive." A bottle of Odor destroyer	F 323	**F 323** **Resident Specific** The IDT reviewed resident # 9's plan of care for fall prevention. Plan is currently appropriate for resident. Chemicals in the shower rooms are locked, Ground Fault Circuit Interrupter's (GFCI) are placed in remainder of resident sink areas, and the fireplace has a protective screen for resident safety. **Other Residents** The IDT has reviewed other residents with a history of recent falls to ensure adjusted plans of care have been implemented as indicated. No additional issues were identified. **Facility Systems** All falls are investigated and documented by the LN. A plan of care to prevent further falls is established and implemented immediately. The IDT reviews all events on the next business day evaluating additional resident information and updating plans of care. Other residents are reviewed for like	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 marked "Eye irritation keep out of reach" was also in the cabinet. b. At approximately 9:20 a.m. on 6/3/08, the shower room in the 100 hallway was noted to be unlocked and the door ajar. The cabinet was open and the contents were the same as the 300 hallway cabinet, including Oasis disinfectant and Odor destroyer. 3. On 6/4/08 at 2:45 p.m. the following items were observed to be plugged into outlets next to sinks: Room 102 - electric toothbrush Room 106 - power strip with appliances plugged in Room 201 - power strip with appliances plugged in Room 214 - electric razor The interpretive guidelines for F323 (revision 27, 08/17/07) indicates that GFCIs are needed in locations near water sources to prevent electrocution of staff and/or residents. The interpretive guidelines referenced the Electrical Safety Foundation International (ESFI) for additional guidance. The ESFI states, "GFCI ...This small, inexpensive device can help prevent electrocution...They monitor the flow of current through the circuit and if they detect any changes (such as occur with a ground fault) they quickly act to shut off the power fast enough to prevent serious injury from electrical shock...Ground faults occur when the electrical current in an electrical appliance...strays outside the path where it should normally flow. Ground faults are often the result of damaged appliance cords or when...electrical products come in contact with water, metal or other conductors in places such as the bathroom, kitchen and laundry room...If a	F 323	situations with adjustments to plans of care as indicated. LN monitor for plan implementation. The executive director (ED) with the maintenance director and/or designee will conduct monthly safety rounds to monitor for safety issues, to include but not limited to, unlocked chemicals, GFCI's in water areas, and the fireplace protective screen. **Monitor** The DNS, ED, Maintenance Director and/or designee will review at least 2 residents weekly with falls for appropriate interventions of accident prevention and other safety issues. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 10, 2008	

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	135021	A. BUILDING _____ B. WING _____	06/05/2008

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F 323	Continued From page 20 person provides a path for the live current to the ground, he or she may be severely shocked or even electrocuted. GFCIs act quickly to intercede and shut off the flow of electrical current through the circuit (and a person), helping to prevent injury or death..." On 6/4/08 at 3:15 p.m., the maintenance supervisor was asked if the outlets were on a circuit with a GFCI. He replied, "No," and stated as rooms were being remodeled GFCI were being installed, but the other rooms did not have them. The maintenance supervisor took immediate steps to remove the electrical appliances and power strips from the outlets. 4. On 6/3/08 at 2:30 p.m. the glass doors and metal surround of the gas fireplace in the facility lobby were determined to be at a temperature of 250 degrees Farenheit. Residents were noted to be in the area unattended. The fireplace was observed to be without a protective screen. The Administrator was immediately informed of the fireplace temperature and shut it off. By 4:30 p.m. the fireplace had been equipped with a protective screen. Based on observation, staff interview, and record review, it was determined that the facility failed to implement consistent and adequate measures to prevent resident falls and did not ensure residents were protected from potential environmental hazards. This was true for 1 of 17 sampled residents (#9) who was transferred without a gait belt resulting in falls, residents residing in 4 of 51 rooms (Room 102, Room 106, Room 201, Room 214) which had plug-in sockets located directly	F 323		

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F 323	Continued From page 21	F 323		

above the sinks without GFCI (Ground Fault Circuit Interrupter) protection, and residents who were cognitively impaired in the 100 and 300 halls where chemicals were found unsecured. In addition, 1 of 1 unproected gas fireplaces was determined to be at a temperature of 250 degrees Farenheit which had the potential for injury if a resident fell or leaned against the fireplace. The findings include:

1. Resident # 9 was admitted to the facility on 4/29/1998 with diagnoses of cerebral vascular accident with hemiplegia, seizure disorder, malaise, fatigue, and chronic urinary tract infections.

The resident's annual MDS, dated 10/05/07, documented the following:
* Short and long-term memory impairment
* Modified independence related to cognitive skills for daily decision making
* Extensive one person physical assistance for bed mobility, transfers, dressing, and toilet use, dressing, and bathing
* Physical assistance required for balance tests
* Full loss of range of motion on one side [right side] for arm, hand, leg, foot
* History of falls within the preceding 31-180 days

Resident #9's care plan, dated 10/16/07, listed problems of, "impaired physical mobility" and "fall risk" related to seizure activity, weakness, neuromuscular impairment, and osteoarthritis. The care plan instructed staff to transfer with the assistance of 1-2 staff using a gait belt.

CNA Flow Sheet Records for October 2008 through December 2008 stated, "Transfer w[ith]/assist of 1-2 w[ith] gait belt at all times."

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F 323	Continued From page 22 Nurses notes, dated 12/26/07, reported, "Rsdt [resident] fell to floor during transfer from wc[wheel chair] to toilet ... rsdt denies pain, uncertain if hit head. Will continue to monitor. No s/sx [signs/symptom] injury." An undated Post-Event Investigation/Interview form stated that the resident tried to rush when getting out of the wheelchair and the CNA did not "have time to take appropriate action." The report listed the time of the incident as 7:35 pm, and stated a gait belt was not in use at the time of the fall. A Resident Event Report Worksheet dated 12/28/07 stated, "IDT [interdisciplinary team] met 12/27/07 to discuss recent event fall [on] 12/26/07. Rsdt [with] hx [history] of seizures, weakness, R [right] flaccid side. Upon investigation rsdt was being toileted by aide. It appears that rsdt attempted to stand up quickly and aide was not prepared, [and] rsdt fell to floor. Plan: Inservice aide re: gait belt." Other than increased supervision and staff education, no other corrective actions were recommended on the report (including updating the care plan). Review of the care plan, dated 10/16/07 (effective for the time of the incident), as well as subsequent care plans, listed no additional modifications or updates regarding fall risk or fall precautions when toileting. Resident #9's quarterly MDS assessment, dated 1/4/08, documented the same status as the annual MDS assessment but added a," fall within the past 30 days." Nurses notes, dated 4/23/08, documented the nurse was, "Informed that [Resident #9] was on	F 323		

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F 323	Continued From page 23 the floor in the BR [bathroom]. [Resident #9] was found [with] R [right] leg curled under her. CNA stated rt [right] arm was under pt [patient] when she fell. ROM [range of motion] in RLE [right lower extremity] + [and] RUE [right upper extremity] is WNL [within normal limits] for elder. [Resident #9] Denies pain..." The Post-Event Investigation/Interview form (no date) for the event documented the fall was attended. The CNA assisting the resident, at the time of the fall, documented she did not know how the fall occurred. The CNA stated she was assisting the resident to use the bathroom and had just placed the resident in the wheelchair when, "Suddenly she was on the floor." The CNA stated she thought the brakes were locked, but indicated the wheelchair moved during the transfer. The CNA documented she was not using a gait belt at the time of the fall. The report listed the time of the incident as 4:00 pm. A Resident Event Report Worksheet dated 5/2/08 stated, "IDT [interdisciplinary team] met 4/24/08 to discuss recent event. Rsdt [with] hx [history] of R [right] sided weakness. Rsdt was being transferred from toilet to w/c [wheel chair] when it appears the w/c moved & [and] Rsdt went to floor. Plan: Inservice." The Post-Event Action portion of the event report documented the care plan would be updated, supervision and staff would be educated. Review of the care plan dated 4/30/08 listed no modifications or updates regarding fall risk or fall precautions when toileting. Review of a third Resident Event Report Worksheet revealed another fall that occurred on 5/08/08. During this fall a CNA was assisting the resident to transfer to the bathroom when the CNA hear a loud pop. The resident called out in	F 323		

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F 323	Continued From page 24 pain and the CNA, who was wearing a gait belt, lowered the resident to the floor and called for LN assistance. An x-ray, dated 5/8/08, documented severe, diffuse, demineralization of the right leg with a tibia and fibular head fractures. The report indicated the fractures were likely being pathological in nature versus caused by the transfer or fall. During observations of morning cares on 6/3/08 at 8:55 am, Resident #9 was observed to be transferred to from the bed to her wheel chair by two CNAs using a Hoyer lift. The CNAs stated the Hoyer lift was used during all transfers from the bed to the chair to prevent falls. During an observation of personal cares on 6/4/08 at 3:10 pm, two CNAs were observed to assist the resident to bed using a Hoyer lift and then place her on a bed pan. The resident voided in the bedpan, was given pericare, and then positioned for a nap. When asked if the resident used the bathroom during the day, the CNAs stated that, since a recent fall (5/08/08), the resident used the bedpan and attends versus transfering from the wheelchair to the toilet. Resident #9's care plan, dated 4/30/08, did not list the Hoyer lift or a bed pan (used during the day or evening) as interventions to prevent falls. The care plan did state the resident was to be offered a bed pan at 12:00 midnight and 4:00 am to assist with incontinence. The CNA flow sheets for May and June 2008, did not list day or evening use of the bedpan or use of the Hoyer lift for transfers. The DON and nurse consultant were interviewed on 6/4/08 at 4:00 pm, and 6/5/08 at 8:30 am, regarding the resident's falls, the lack of use of a	F 323		

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F 323	Continued From page 25 gait belt to prevent the falls, and fall prevention interventions that were implemented and added to the resident's care plan and CNA flow sheets.The interviews confirmed that a gait belt was not used by the CNAs on 12/26/07 or 4/23/08. Use of the gait belts was specified on the resident's care plan and required by facility policy. Counseling of the CNAs, following the first two falls, was confirmed, but no further documentation was provided to show interventions added to Resident #9's care plan, or CNA flow sheets, following any of the falls.	F 323	Phone conversation with the DON on 7/3/08. Examples of non-pharmacological interventions include: back rubs, soft, music. Care plan instructs staff to attempt multiple interventions if needed. KD	
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329** **Resident Specific** The LN administration team reviewed resident #2 & 4 related to unnecessary drugs. Precautions for acetaminophen maximum daily dosage was added and non-pharmacological interventions were established for use prior to showering resident including updates to the plan of care. **Other Residents** The DNS and/or designee reviewed residents for lack of acetaminophen precaution and unnecessary drugs. No additional records or concerns were identified. **Facility Systems** Acetaminophen precautions are routinely added to Medication Administration Records. Physician Recaps are reviewed monthly to monitor compliance. Behavioral interventions are required prior to behavioral medication implementation. Re-education was provided to LN's regarding unnecessary drugs including but not limited to, acetaminophen precautions and need for	

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F 329	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility did not ensure that orders for acetaminophen and drugs containing acetaminophen included precautions regarding maximum dose per 24 hours and that non-pharmacological interventions were considered and used instead of or in addition to medications. This affected 2 of 17 (#2 & #4) sampled residents. The findings include: 1. Resident #4 was admitted to the facility on 12/1/03 with diagnoses of sick sinus syndrome with complete heart block, dementia, generalized pain and hypertension. Resident #4's 4/10/08 quarterly MDS stated the resident was cognitively impaired and was resistant to care. The resident's 6/08 physician recapitulated orders included the following medications: Zyprexa (antipsychotic) 1.25 milligrams [mg] every morning and at 4:00 a.m. for dementia with fearfulness/agitation/combativeness, Paxil 20 mg every morning at 4:00 a.m. for depression, Depakote 125 mg twice daily for dementia with behavioral disturbances, Zyprexa 1.25 micrograms [mg] as needed for dementia with fearfulness/agitation/combativeness, Hydrocodone 5 mg/acetaminophen 325 mg 10 milliliters [ml] liquid twice daily for pain, Duragesic patch 50 mcg changed every 72 hours for pain and Hydrocodone 5 mg/acetaminophen 325 mg 10 ml liquid every 6 hours as needed for pain. On 4/7/08 the physician ordered Trazodone	F 329	non-drug interventions prior to behavioral medications. **Monitor** The DNS and/or designee will review two residents monthly with acetaminophen for appropriate precautions. Also, two residents with behavioral medications will be reviewed weekly for non-pharmacological interventions prior to medication use. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 10, 2008	

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F 329	Continued From page 27 (antidepressant) 25 mg before showers for agitation related to behavior with cares. Behavior monitoring reviewed for 2/08, 3/08 and 4/08 revealed the following: 2/19/08 - Screaming and scratching during dressing change 3/08 - No behaviors documented 4/9/08 at 9:00 am - Yelling, complained of leg pain 4/9/08 at 11:00 am - Screaming, yelling, scratching and kicking during shower According to MARs Resident #4 received the Trazodone prior to showers on 4/9, 4/12, 4/16, 4/30, 5/07, 5/13 and 5/21/08. Resident #4's 2/23/07 care plan, updated 4/30/08, included a problem of "Thought processes impaired R/T [related to] dementia W/ [with]behavioral disturbances." Approaches listed behaviors exhibited by the resident which included swearing/verbal abuse, combative behavior and refusal of care. Instruction to staff included providing brief 1 - 1 staff attention, assessing pain needs and checking for side effects of psychotropic medications. On 6/4/08 at 2:45 p.m. the Social Worker, RN and RN Consultant were interviewed in regard to the addition of the "as needed" antidepressant to Resident #4's regimen. They confirmed there was no documentation of attempts at non-pharmacological interventions prior to the start of the Trazodone. 2. Resident #2 was admitted to the facility 04/28/08, with diagnoses of dementia with Lewy Bodies dementia, Parkinson's disease, malaise	F 329		

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F 329	Continued From page 28 and fatigue, dehydration, and arthropathy. May and June 2008 physician recapitulation orders stated the resident received acetaminophen 650 mg [milligrams] by mouth every 4-6 hours as needed for pain. The 6/08 MAR documented the resident could receive acetaminophen 650 mg by mouth every 4-6 hours as needed for pain and Darvocet N100 (contains acetaminophen) by mouth every 4 hours as needed for pain. Table 1 of F329 (Unnecessary Drugs) states the following concern with acetaminophen (Tylenol), "Daily doses greater than 4 grams/day [4000 mgs per day] from all sources (alone or as part of combination products) may increase risk of liver toxicity." The total potential daily dose from the Acetaminophen and Darvocet N100 was 7800 mgs per day. Warnings not to exceed 4000 mg per day were not found on the 6/08 MAR or physician recapitulation orders.	F 329		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	**F356** **Resident Specific** No resident numbers were indicated. **Other Residents** Nurse staffing data is available in a prominent location in the entry hallway at wheelchair height as noted in the statement of deficiencies. **Facility Systems** Nurse staffing data is consistently posted at the new location in the entry hallway.	

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F 356	Continued From page 29 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility did not ensure that nurse staffing data was posted in a prominent place readily accessible to residents and visitors. This had the potential to affect 100% of the residents of the facility. The findings include: On 6/3/08 at 9:30 a.m. the nurse staffing posting was observed in the 200 hallway. The posting was attached to a board which hung on the wall of an alcove area on the side of the hallway. The posting was well above eye level for a standing person, and a laundry cart parked in the alcove prohibited close access. The posting would not have been readily accessible to visitors or residents in wheelchairs. The Administrator was informed of the issue on 5/4/08 at 4:15 p.m. On arrival at the facility on 5/5/08 at 7:45 a.m. the	F 356	**Monitor** The ED and/or designee will monitor for daily posting at the new location in the entry. Any concerns will be discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 10, 2008	

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F 356	Continued From page 30 board with nurse staffing posted was observed to be in the lobby area at a height visible from a wheelchair.	F 356		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure that food-contact surfaces on cereal/soup bowls and beverage mugs were free from debris prior to being placed in clean dish storage areas, and food-contact surfaces on lipped plates were smooth and easily cleanable. This had the potential to affect any residents who used the lipped plates, ate from cereal bowls, or drank from beverage mugs. The findings include: 1. During the initial kitchen tour on 6/2/08 at 3:30 pm, the surveyor evaluated 7 purple plastic bowls and 8 purple plastic beverage mugs for cleanliness and serviceability. Two of the plastic cereal/soup bowls, and four of plastic beverage mugs, were observed to have dried debris on their food-contact surfaces. These items had previously been washed and air dried in the dishwashing area then stored inverted in the clean dish area. During the tour, the Dietary Services Manager (DSM) immediately removed the crusted bowls and mugs from the clean dish storage.	F 371	**F371** **Resident Specific** No specific resident numbers were indicated. However, there have been no residents served on soiled dishware. The new dishwasher has been installed and the dishes are observed to be clean. The plastic lipped plates have been replaced with metal high wall plate rims, as the plastic scarred easily when cutting. **Other Residents** Food service employees have been in-serviced related to monitoring service ware for cleanliness prior to storing, not simply prior to use. **Facility Systems** Food service employees receive in-service education during orientation, annually, and as needed thereafter related to sanitation and proper food handling. The Certified Dietary Manager and/or Registered Dietician will observe for cleanliness of service ware. **Monitor** The ED will observe kitchen service ware cleanliness weekly. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 10, 2008	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 31 During the tour, an industrial dishwasher was observed to be empty and opened to air. A large amount of white plastic repair foam was noted wrapped around one outside corner of the washer. When asked about the repair foam, the DSM commented that the dishwasher was old and was due to be replaced. The DSM stated the replacement was scheduled for 2:00 pm the following day (6/3/08). The DSM indicated the primary reason for replacing the dishwasher was it's age and a large leak on the underside of the dishwasher. During a visit to the dishwashing area on 6/3/08 at 3:00 pm, it was noted that a new dishwasher had not yet been installed. A staff in the dishwashing area confirmed that the dishwasher was due to be replaced. The staff commented that the dishwasher was old, leaking, and was not always effectively cleaning the dishes. On 6/3/08 at 3:30 pm, the DSM confirmed that there had been some problems with the dishwasher not washing dishes thoroughly. When asked how the facility ensured dishes were clean prior to using them for food service, the DSM stated that plates were checked in the dish room (because their food-surfaces were easily visible when removing them from the dishwasher). She indicated that items, such as the plastic beverage mugs, came inverted from the dishwasher,were kept inverted and air dried in the dish room, then placed (inverted) with other dishes in the clean dish storage area. The food-surface areas of these items were not visualized by staff until food was placed in them in preparation for the next meal/snack. If staff found food/debris on food-surface area when filling the dishes, the dish was removed and placed back into the dirty dish	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135021	A. BUILDING _____ B. WING _____	06/05/2008

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F 371	Continued From page 32 area. Chapter 4, subparagraph 4-601.11, page 129, of the 2005 FDA Food Code indicated, "(A) Equipment, Food-Contact Surfaces, and Utensils shall be clean to sight and touch". The facility was aware that the industrial dishwasher was not effectively removing all food particles/debris from food, but failed to develop a system to ensure that dishes placed in the clean dish storage area, were free from dried food/debris. 2. During the initial kitchen tour, the surveyor evaluated eight plastic cream colored, lipped dinner plates for cleanliness and serviceability. These plates were stored on a serving table next to the tray line steam table. Three of the plates were noted to have fine gouges and scratches on their food contact surface making them rough to touch. The DSM immediately removed and discarded these plates during the tour commenting that the plastic plates scratched easily and were frequently needed to be replaced. Chapter 4, subparagraph 4-101.11, page 102, of the 2005 FDA Food Code indicated, materials that are used in the construction of utensils and food-contact surfaces must be, "(D) Resistant to pitting, chipping, crazing, scratching, scoring..." On 6/5/08 at 12:45 pm, the DSM explained that they would discarded the plastic lipped plates and use metal plate guards to meet the needs of the resident's needing lipped plates.	F 371		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION	F 444	**F444** **Resident Specific**	

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F 444	Continued From page 33 The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not ensure staff providing resident perineal care washed hands before initiating other resident care. This was true for 2 of 14 sampled residents (#1 and #2). Findings include: According to October 25, 2002, Center for Disease Control guidelines, "The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and health care personnel from infection." 1. Resident #1 was admitted to the facility on 7/24/06 and was readmitted on 2/17/07 with diagnoses of congestive heart failure, chronic airway obstruction, vascular dementia, atrial fibrillation, paranoid state and hypertension. On 6/3/08 at 10:00 am, two CNAs were observed assisting Resident #1 with toileting in her bathroom. One CNA performed peri care while the other assisted the resident with standing. The resident was then transferred to the wheelchair and the CNA who performed peri care wheeled the resident out of the bathroom, without removing gloves and washing her hands. After placing the resident near her bed, the CNA lifted the resident's shirt and repositioned the resident's	F 444	The Staff Development Coordinator (SDC), DNS and/or designee reviewed resident #'s 1 & 2 related to infection control techniques with handwashing. Direct care staff was coached on infection control techniques with appropriate handwashing and glove use. **Other Residents** The LN management team reviewed other residents requiring toileting and/or peri-care for appropriate handwashing and glove use by direct care staff. In-service education and skills checklists for competency is initiated for direct care staff related to handwashing and glove use. **Facility Systems** Direct care staff receive in-service education upon hire and at least annually regarding infection control with individual skill checklist demonstration for competency in handwashing. SDC, DNS, LN supervisor, and/or designee will observe for compliance with infection control practices during daily routine rounds. **Monitor** The DNS, SDC, and/or designee will round and observe handwashing practices at least weekly. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate. **Date of Compliance** July 10, 2008	

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F 444	Continued From page 34	F 444		

PEG [percutaneous endoscopic gastrostomy] tube, handling it with her contaminated gloves. She then reinstalled a lap buddy on the resident's wheelchair. After this resident care was completed, the CNA removed the contaminated gloves and washed her hands.

On 6/5/08 at 10:40 am, the Administrator and DON were made aware of the incorrect handwashing techniques of the staff observed. No further information was provided by the facility.

2. Resident #2 was admitted to the facility on 04/28/08, with diagnoses of dementia with Lewy Bodies, Parkinson's disease, malaise and fatigue, dehydration, and arthropathy.

The resident's care plan, dated 04/28/08, documented, "Check for incontinence Q2 [every two] hours and prn (as needed)."

On 6/3/08 at 11:20 am, a CNA was observed assisting Resident #2 with peri-care. During peri-care, a soiled towelette fell on the floor beside the resident's bed. The CNA completed the peri-care, removed her gloves, and washed her hands. The CNA proceeded to pick up the dirty towelette, ungloved, and threw it into the trash can. The CNA did not wash her hands. The CNA then assisted in transferring resident with Hoyer lift into chair, and also combed the resident's hair. The CNA did wash her hands before taking the resident to the television room.

On 6/5/08 at 10:40 am, the DON and Administrator were notified of the lack of handwashing by staff following assistance with peri-care.

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Mark Sawmiller, RN, Team Coordinator Arnold Rosling, RN, QMRP Amanda Bain, RN Lorraine Hutton, RN Lea Stoltz, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record FSM = Food Service Manager	C 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Rehabilitation and Care Center does not admit that the deficiencies listed on the State Form exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. RECEIVED JUL - 1 2008 FACILITY STANDARDS	
C 147	02.100,05,g g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be	C 147	Refer to the Plan of Correction at F329 Date of Completion: 7/10/08 KD	

Bureau of Facility Standards

Debbie Freeze — Ex Director — 6.24.08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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C 147	Continued From page 1 ordered in writing by the attending physician. This Rule is not met as evidenced by: Refer to F329 as it relates to unnecessary drugs.	C 147		
C 342	02.108,04,b,ii ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 as it relates to hazardous chemicals.	C 342	Refer to the Plan of Correction at F323 Date of Completion: 7/10/08 KD	
C 393	02.120,04,b b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Refer to F246 as it relates to call lights.	C 393	Refer to the Plan of Correction at F246 Date of Completion: 7/10/08 KD	
C 671	02.150,03,b b. Proper handling of dressings, linens and food, etc., by staff.	C 671	Refer to the Plan of Correction at F444 Date of Completion: 7/10/08 KD	

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C 671	Continued From page 2 This Rule is not met as evidenced by: Refer to F444 as it relates to handwashing.	C 671		
C 745	02.200,01,c c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Refer to F281 as it relates to professional standards of practice for medication administration.	C 745	Refer to the Plan of Correction at F281 Date of Completion: 7/10/08 KD	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to care plans.	C 782	Refer to the Plan of Correction at F280 Date of Completion: 7/10/08 KD	
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F246 as it relates to hearing devices.	C 784	Refer to the Plan of Correction at F246 Date of Completion: 7/10/08 KD	

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C 790	Continued From page 3	C 790		
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Refer to F323 as it relates to accidents.	C 790	Refer to the Plan of Correction at F323 Date of Completion: 7/10/08 KD	
C 882	02.203,02,a a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record. This Rule is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure 1 of 1 closed record on a deceased resident (#15), contained a cause of death signed by the attending physician. The findings include: Resident #15 was admitted to the facility on 11/5/07 with the diagnoses of cerebral vascular accident (CVA), seizures, urinary tract infection, cornary artery disease, diabetes mellitus and anemia.	C 882	**Resident Specific** The IDT reviewed resident # 15 closed record. The cause of death has now been signed by the attending physician and filed in the closed record as noted in the statement of deficiency. **Other Residents** Medical Records staff reviewed other residents who had expired and found cause of death evident in the closed records. **Facility Systems** When closing the record of an expired resident, the attending physician is requested to complete the cause of death on the closed records face sheet. A log is kept to ensure timely return of requested information. Medical Records staff will notify the Executive Director for follow-up with non-compliant physicians. **Monitor** The Executive Director will review monthly for physician compliance in documenting the cause of death for resident's expiring at the center. Any concerns will be addressed immediately and discussed with the PI committee as indicated. The PI committee may adjust the frequency of the monitoring, as it deems appropriate.	

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C 882	Continued From page 4 Record review revealed the resident expired on 2/28/08 at 2:00 pm, with no medical cause of death listed by the physician. On 6/5/08 at 9:30 am, the medical records staff member was interviewed concerning the lack of a cause of death, signed by the physician, in Resident #15's closed record. After reviewing the closed record, the medical records staff member stated she could not find any documentation of the cause of death. At 10:15 am the staff member produced a faxed copy of the Certificate of Death with the cause of death identified by the physician. She indicated that it was from the funeral home, she also indicated it was the facilities fourth attempt to get the information.	C 882	**Date of Compliance** July 10,2008	